Disproportionate Share Hospital (DSH) Program: Kansas Reforms (Draft)
August 13, 2007

The Kansas Health Policy Authority is proposing reforms to the current Medicaid Disproportionate Share Hospital (DSH) program which can provide as much as $25.7 M in federal matching funds annually to the state. The goals of these reforms are to: (1) Maintain the state's support for the DSH program and devise a formula that always expends the maximum amount allowed by Federal regulations; (2) Direct resources equitably towards hospitals that provide a high level of services to Medicaid beneficiaries and the uninsured by abandoning the existing two-formula strategy applied to LIUR and MIUR hospitals; (3) Introduce dis-proportionality into the payment formula by increasing reimbursement for facilities that, relative to their size, incur a greater share of the burden of caring for Medicaid eligible individuals and the uninsured in the State of Kansas; (4) Treat losses equally whether attributable to outpatient, inpatient, Medicaid, or uninsured services; (5) Create more predictability and stability in DSH payments over time, lessening the payment "cliff" that faces marginal DSH hospitals.

Background: The federal government provides special funding to hospitals who treat significant populations of indigent patients through the Disproportionate Share Hospital (DSH) programs. In Kansas, the current Medicaid DSH program allows hospitals to qualify for DSH funding in two ways:

- MIUR: The proportion of inpatient Medicaid days to total inpatient days is greater than one standard deviation above the mean for all hospitals that do business with Kansas Medicaid. This is the Medicaid Inpatient Utilization Ratio (MIUR).
- LIUR: Total Medicaid and other public revenue is at least 25% of total hospital revenue. This is the Low Income Utilization Ratio (LIUR), and includes both inpatient and outpatient revenue. Public revenue represents state and local subsidies, not Medicare, VA, etc.

After significant discussion with multiple hospital stakeholders, KHPA recommends maintaining this set of qualifications for DSH payments. However, with proposed changes in payments described below, these criteria will support a significantly-improved distribution of funds towards hospitals providing disproportionate levels of services to Medicaid and the uninsured.

Concerns with the current formula. Kansas Hospitals have historically often received only a proportion of the maximum possible DSH payments because under the current formula we have not been able to "draw down" the maximum federal amount of federal dollars. In addition, the current methodology leads to a number of undesirable outcomes and imbalances:

- Qualifying thresholds for hospitals are high, and payments under the LIUR formula can be substantial – LIUR hospitals received full reimbursement for all losses in 2007. This creates a very large disparity between hospitals that do and do not qualify for DSH payments, and can create very large changes in DSH payments from one year to the next, especially if large hospitals float in and out of the formula. This is exactly what has happened over the last few years, as KU hospital and Children's Mercy Hospitals have come in and out of the formula.
- Medicaid losses are treated differently in hospitals qualifying as MIUR versus LIUR. The MIUR qualifying threshold is high, focusing payments on high-volume Medicaid providers, but these payments cover a smaller fraction of losses than for LIUR hospitals.
- Inpatient and outpatient losses are treated unequally by the DSH formula. Medical treatments frequently migrate from inpatient to outpatient settings, a welcome cost-saving trend, but the Medicaid DSH formula maintains a preference for compensation of inpatient losses, creating undesirable disparities in reimbursement of losses across hospitals with a different mix of inpatient and outpatient care.
- The current methodology does not always result in fully expending all payments allowed by Federal DSH regulations ($42 million for community hospitals). In 2007, $6 million went unallocated (appr. $4 million Federal funds, $2 million SGF).

Key objectives in reforming the DSH formula. The overall goal of DSH reform is to provide financial support for hospitals providing care to those in need, including Medicaid beneficiaries and the uninsured. In the fall of 2006, the KHPA began a transparent process to discuss possible changes to DSH program with concerned stakeholders. The KHPA first met with all hospitals in the fall of 2006 and subsequently convened an advisory workgroup to discuss and review a number of alternative methodologies over the course of several months. This advisory workgroup provided needed feedback on a number of possible DSH reform

formulas. The KHPA Board was apprised of the advisory groups' progress. The reformed formula is designed to meet the following objectives:

- Maintain the state's support for the DSH program and devise a formula that always expends the maximum amount allowed by Federal regulations.
- Direct resources equitably towards hospitals that provide a high level of services to Medicaid beneficiaries and the uninsured by abandoning the existing two-formula strategy applied to LIUR and MIUR hospitals.
- Introduce dis-proportionality into the payment formula by increasing reimbursement for facilities that, relative to their size, incur a greater share of the burden of caring for Medicaid eligible individuals and the uninsured in the State of Kansas.
- Treat losses equally whether attributable to outpatient, inpatient, Medicaid, or uninsured services.
- Create more predictability and stability in DSH payments over time, lessening the payment "cliff" that faces marginal DSH hospitals.

Payment formula changes. The draft methodology begins with each facility's percentage of losses to total costs. Losses include those attributable to Medicaid, the uninsured, outpatient and inpatient services. This percentage reflects the burden of uncompensated care each facility incurs and allows for comparisons among facilities. These percentages range from essentially 0% to 20%, but most hospitals' losses fall between 0% and 9%. This burden rate is then normalized (ie rebased) between 0% and 100% to determine each facility's percentage rank, a measure of disproportionate burden. Roughly speaking, this percentage rank is equal to each hospital's loss ratio expressed as a percentage of the highest loss ratio observed among Medicaid-participating hospitals. To obtain the proportion of losses covered, a base percentage is added to each percentage rank. This base percentage serves as a means to ensure that the federal allotment is neither underspent nor exceeded. The resulting DSH payment for each facility is literally this proportion of their qualifying Medicaid and uninsured losses. The raw formula puts reimbursement at greater than 100% of losses for some facilities, but reimbursement is capped at a facility's losses. The facilities with the highest burden of uncompensated costs relative to their peers will have the highest percentage of its allowable losses covered. Conversely, the facilities with the lowest burden of uncompensated costs will receive the lowest percentage of loss coverage.

Additional DSH reforms. With input from a wide variety of hospitals, and based in part on the advice and feedback of the technical advisors participating in the workgroup, KHPA also recommends:

- ***Change the base Medicaid reimbursement for Kansas Critical Access Hospitals*** (CAH) to cover costs (cost based reimbursement, consistent with how Medicare pays CAHs). By removing these small rural hospitals -- crucial to providing services across a rural state such as Kansas -- from the DSH pool, we free up funds to be applied to other hospitals' losses.
- ***Limit 10% of Kansas Medicaid DSH payments for out-of-state community hospitals*** in order to ensure that the majority of DSH funds pay for losses to Kansas hospitals (excludes payments to state psychiatric facilities).
- ***Excluding the Kansas University Hospital Authority from the DSH formula***, given their unique Medicaid payment formula as a public hospital.
- ***Provide a smooth three-year transition to the new methodology*** in FY 2008-2010 to give DSH hospitals adequate time to adjust to the new DSH formula.
- ***Provide one-time 50% payments to multi-year DSH hospitals that lose eligibility*** (applies on an ongoing basis).

Summary. Hospitals in Kansas provide essential services to Medicaid beneficiaries and the uninsured throughout the State. The Kansas Health Policy Authority is proposing reforms to the current Medicaid Disproportionate Share Hospital (DSH) program to create a more equitable, rationale, and predictable formula for hospitals who treat a significant populations of indigent patients. The KHPA recommends re-crafting the DSH formula, paying Critical Access Hospitals cost based reimbursement for Medicaid, capping the amount of funding for out-of-state hospitals, and removing the KU Hospital Authority from the DSH formula, and in order to meet the objectives agreed to by stakeholder hospitals and supported by the KHPA Board.